Psychiatric consequences of radical curative surgery for gastric cancer

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SUMMARY

Radical resection of gastric cancer offers the best hope of cure, but carries the risk of significant psychological morbidity in addition to the well-documented physical complications. In the case presented, recognition of clinical depression after thoracoabdominal gastrectomy enabled successful psychological intervention.

CASE HISTORY

A 51-year-old man, who had an adenocarcinoma of the gastro-oesophageal junction, underwent radical total thoracoabdominal gastrectomy with distal pancreatectomy, splenectomy, and roux-en-Y oesophagojejunostomy. He was discharged home after 12 days; the tumour stage was T_2 N_0 M_0 (Stage I). He was readmitted 4 months later, with weight loss (13 kg) and malaise. His symptoms were thought to be secondary to pancreatic insufficiency and rapid gastrointestinal transit. Clinical depression was detected using the hospital anxiety and depression (HAD) scale[1], and the diagnosis confirmed by the criteria of the American Psychiatric Association[2]. Despite prescription of pancreatic supplements, codeine phosphate, and nasogastric feeding he only regained his pre-operative weight after treatment for depression. His psychological symptoms improved after counselling and prescription of dothiepin (Figure 1). Twenty-four months after operation he was well with no signs of tumour recurrence.

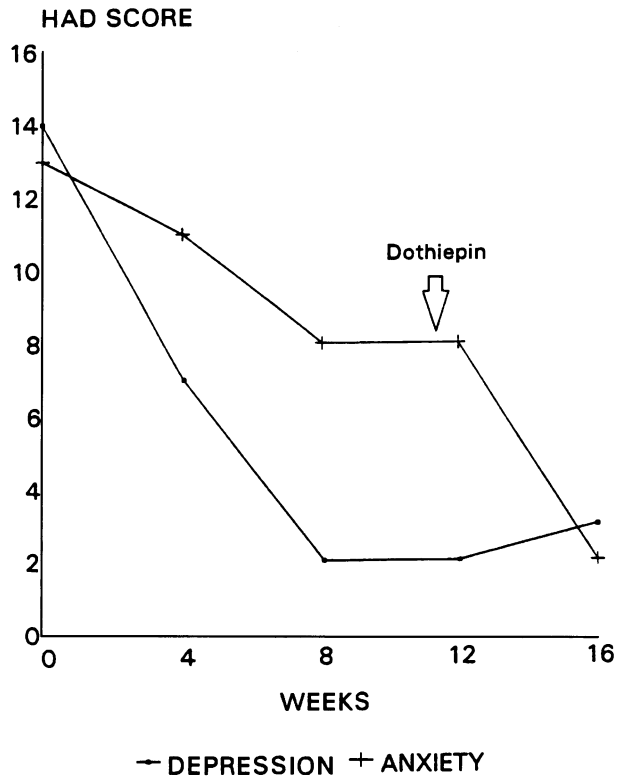

Figure 1 **Change in hospital anxiety and depression (HAD) scores for depression (□) and anxiety (+) after commencement of counselling (week 0) and prescription of dothiepin (week 11)**

DISCUSSION

Early gastric cancer is associated with an excellent prognosis after surgery. Five year survival may be greater than 90% in patients with Stage 1 gastric cancer after radical resection[3]. Open access gastroscopy is expected to increase the proportion of UK patients in whom potentially curable gastric cancer is detected[4]. However, the consequences of major surgery can be formidable.

In the case presented, the emotional challenges of the patient's diagnosis and operation were substantial, but it was possible to treat them successfully. The incidence of anxiety and depression after major surgery is unknown, but is almost certainly underestimated by surgeons. The HAD scale enables non-psychiatric-trained clinicians to screen patients for significant emotional disease, and can detect patients who would benefit from psychiatric intervention. Scores of 11 or more for either depression or anxiety correlate well with a clinical diagnosis of depression. The depression subscale predominantly measures anhedonia and is not influenced by physical symptoms[1]. The patient made a prompt recovery from radical surgery, and although nutritional problems were

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encountered in convalescence, would be regarded as a surgical cure. Psychological intervention has reduced psychiatric morbidity after other oncological surgical procedures[5].

CONCLUSION

The surgeon who performs extensive oncological surgery must be aware of not only the physical, but also the psychological consequences of the operation. After radical surgery, psychological intervention may be required, but can only be offered if the necessity is recognized. In the case presented the weight loss and lassitude could easily have been misinterpreted as manifestations of recurrent tumour. Practitioners responsible for management of oncology patients should be aware of methods which screen for psychological illness.

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